morbidity but what it does to youth, to marriage, and to the home.—I am, etc.,

H. C. McLAREN.

Queen Elizabeth Hospital,
Birmingham.

Charlotte Brontë's Mercurialism

SIR,—Soon after reading about the two unusual cases of mercurial poisoning reported respectively by Drs. H. R. M. Johnson and O. Koumides and Dr. D. M. Hill (11 February, pp. 340 and 342) I came across an account by the great Victorian novelist, Charlotte Brontë, of the severe attack of mercurialism from which she suffered as a result of taking pills prescribed by her doctor. She described her symptoms in a letter to Margaret Wooler dated 20 January 1852, an extract from which reads as follows[1]: ". . . My Doctor called the next day; he said the headache from which I was suffering arose from inertness in the liver—prescribed some alterative pills and promised to call again in a week. I took the pills duly and truly—hoping for benefit—but every day I grew worse; before the week was over I grew very ill—unable to swallow any nourishment except a few teaspoonfuls of liquid per diem, my mouth became sore, my teeth loose, my tongue swelled, raw and ulcerated while water welled continually into my mouth. I knew by this time that Mercury had formed an ingredient in the alterative pills and that I was suffering from its effects. When my Doctor came and found me in this condition he was much shocked and startled, a result had been produced which he had not intended, nor anticipated: according to him the dose of blue pill he had given was not sufficient to salivate a child—and he talked much about exceptional sensitiveness of constitution etc. . . ."—I am, etc.,

J. TODD.

High Royds Hospital,
Ilkley, Yorks.

REFERENCE

1 Wise, T. J., and Symington, J. A., *The Brontës: Their Lives, Friendships, and Correspondence.* Shakespeare Head Brontë Series, 1932, 3, 308. Oxford.

Epidemiology of Alimentary Cancer

SIR,—In reply to Dr. F. Avery Jones's request (14 January, p. 110), there are a number of epidemiological surveys in progress in various parts of the world. Information on any subject of cancer research can be obtained from the World Health Organization, which body has just completed coding all available information on cancer registries. A number of research projects in various parts of the world are beholden to the National Cancer Institute of Health, Bethesda, for funds, and these people too have a system of coding information on research projects which is available for the asking.

We have in the Transkei an epidemiological and aetiological survey which has been in progress since 1956. Here we have a high incidence of oesophageal cancer with a clear-cut variation in incidence from district to district, as well as familial clumping. We are investigating a number of factors which seem likely to have aetiological significance, including toxic plants. It is interesting that some of the plants mentioned by Salem (26 November 1966, p. 1325) are also eaten by the Xhosa in the Transkei. I agree with him that a survey among the Bedouin in Kuwait would help our knowledge of the subject considerably. If Dr. Avery Jones is interested I will with pleasure send him published work on the Transkeian project.—I am, etc.,

ELIZABETH F. ROSE.

Bantu Cancer Registry,
P.O. Box 38,
Butterworth,
Transkei,
South Africa.

Bleeding Peptic Ulcer

SIR,—May I acknowledge with deep appreciation the letter and comments from Mr. N. C. Tanner (4 March, p. 564).

Hitherto we have been reluctant to do a hemigastrectomy with a Roux-en-Y anastomosis without vagotomy because of the magnitude of acid secretion which returns after biliary diversion. With my colleagues Mr. W. M. Capper and Mr. J. Kilby the cause, nature, and effects of the "pyloric regurgitation syndrome" are being investigated, and the problem of multiple erosions seems to be one aspect of this. As Mr. Tanner has emphasized, we must proceed with caution and in a logical manner. Evidence is accumulating on the effects of biliary regurgitation and on the extent and speed of return of acid secretion after biliary diversion. It is still too early to be certain about the procedure of choice. However, when all the findings have been studied, we hope to present them in a manner with which Mr. Tanner will be in full accord—"all shipshape and Bristol fashion."—I am, etc.,

T. J. BUTLER.

Frenchay Hospital,
Bristol.

Malaria in Children

SIR,—Dr. H. M. Gilles, in his excellent article "Malaria in Children" (3 December 1966, p. 1375), appears to pay too little attention to differential diagnosis. He says, "malaria must be suspected in any sick child exposed to the infection."

In our experience here we have found that there can be a serious risk of overlooking sleeping sickness where this disease occurs, and so I feel that any patient from an infected area who presents with "clinical malaria" (often with negative blood slides) must be investigated for sleeping sickness, and this is particularly important in patients with high fever who show little or no response to antimalaria, as otherwise cases have been misdiagnosed.—I am, etc.,

J. MARGARETE GRAY.

District Hospital,
Kisii, Kenya.

SIR,—In answer to Dr. R. M. Sykes's letter (18 February, p. 425), I wish to point out that chloroquine given orally is rapidly and almost completely[1 2] absorbed through the gastrointestinal tract. The main indication for giving it parenterally is vomiting. On the other hand, if a child rejects it on account of its bitter taste it could be administered in some such vehicle as syrup of orange to disguise its taste.

As I stated in my letter,[2] I find this drug can still be administered by mouth if there is vomiting after giving an anti-emetic, and, while waiting for the effect of this, tepid sponging and other symptomatic treatment temporarily brings down the temperature a few degrees and allays restlessness. This is from my experience of several years in a malarious endemic area.

If Dr. Sykes agrees that intramuscular chloroquine can be fatal, and since it is known that cerebral malaria can also be fatal, why combine two fatal possibilities, considering also that what he quotes from Jelliffe[3] justifying the use of intramuscular chloroquine was based only on suspicion even before the blood was examined for parasites? Further, quinine parenterally is still considered of value in the treatment of cerebral malaria. The cardinal principles of intravenous therapy are high dilution and slow administration.[5]

Seaton[4] recommended intravenous chloroquine for the severe cases characterized by unconsciousness, vomiting, etc., but I am rather chary to advocate its use in this way.—I am, etc.,

A. F. TUBOKU-METZGER.

Mitcham, Surrey.

REFERENCES

1 *Chemotherapy of Malaria*, 1961, W.H.O. Tech. Rep. Ser., No. 226, p. 11.
2 *Chemotherapy of Malaria*, 1955, W.H.O. Monograph, No. 27, p. 44.
3 Tuboku-Metzger, A. F., *Brit. med. J.*, 1964, 1, 1378.
4 Jelliffe, D. B., *J. Paediat.*, 1966, 69, 483.
5 *Chemotherapy of Malaria*, 1955, W.H.O. Monograph, No. 27, pp. 32 and 79.
6 Seaton, D. R., *Practitioner*, 1965, 195, 507.

SIR,—I have been reading the correspondence following Dr. H. M. Gilles's article on "Malaria in Children" (3 December 1966, p. 1375).

It is my own impression, as is that of Dr. A. R. F. Williams (17 December 1966, p. 1531) and Dr. A. F. Tuboku-Metzger (21 January, p. 174), that parenteral chloroquine is associated with sudden death. Several doctors, including myself, have seen or heard of such cases. However, it must be remembered that most patients who are given intramuscular chloroquine are usually seriously ill and may be terminal.

Many children with malaria vomit chloroquine. I have been using chloroquine sulphate as suppositories in all such cases and I find that the results are extremely satisfactory. They are of French preparation and are either 150 mg. or 300 mg.—I am, etc.,

R. W. SPARROW.

Lagos, Nigeria.

Allergy in Eczema

SIR,—Dr. Bernard C. Tate (18 February, p. 430) was disappointed that I dismissed allergy as a factor in infantile eczema (10 December 1966, p. 1435), yet I was only reflecting the inability of investigators to prove that there is a reliable relationship between skin tests, food allergy, and the causation of eczema.

I quoted the work of Dr. R. H. Meara,[1] who showed that elimination of eggs from the diet of infantile eczema children with egg sensitivity shown by skin tests did not improve their eczema, though some suffered from urticaria on being fed eggs. Cooke[2] gave a variety of foods to 27 infants with